California MEDICAL ASSOCIATION

NOTICES & REPORTS

FEES—Relationship of Values

Report of the Committee on Fees of the Commission on Medical Services on The Results of Relative Value Study

Editor's Note: **The relative value report herein referred to was adopted by the Council of the California Medical Association February 12, 1956. The extensive detailed lists of unit values for all the various medical procedures are not yet ready for widespread distribution. They are being prepared and it is expected they will be available about May 1.**

To the Council of the California Medical Association:

Assignment and Techniques

Since August 1952, the California Medical Association has repeatedly expressed the need for study of and information on the relative money-value of one medical service to another. For instance, if an appendectomy is worth "x" dollars, how much added to "x" would constitute a reasonable fee for a hysterectomy? To the best of our knowledge, no definitive study of this problem has ever been made.

On March 10, 1953, the Commission on Medical Services of the California Medical Association appointed a subcommittee on Principles of Fee Schedules* in order to develop this information, the purpose of which was to bring order out of several varieties of chaos:

1. The chaos of many county medical society fee studies, no two of which contained similar procedures, or similar nomenclature, and which were, therefore, not useful from a statewide point of view.

2. The chaos of some private insurance company fee schedules, which express no rational relationship between fees.

Such information will also assist in continuing the improvement of C.P.S. fee schedules.

In order to save money and effort, the committee first tried to develop a statewide fee relationship from the mass of information available in other fee studies. Because of the variations in techniques, nomenclature, and numbers and types of procedures, we were forced to abandon this technique and to make our own survey, using the standard nomenclature of the Blue Cross-Blue Shield Actuarial and Statistical Manual.

After developing a survey questionnaire, we started with a pilot survey in Orange and Sacramento counties, in order to make our mistakes on a small, but representative scale. We reported what we learned, and were given $15,000 with which to conduct a statewide survey.

Forty-seven hundred California physicians responded to this survey, and the information obtained from their responses was transcribed to IBM cards. An established statistician, recognized for his work

*Changed to Committee on Fees in 1955. Members: F. G. Hollander, San Diego; Donald C. Harrington, Stockton; Henry Dean Hoskins, Oakland; Leon O. Desimone, Los Angeles; James Graeser, Oakland; DeWitt K. Burnham, San Francisco; Orville W. Cole, Long Beach; Francis J. Cox (chairman), San Francisco.

in medical economic research, came to California to consult with us and after careful examination, he assured us that our information and sample were adequate and worthy of statewide application.

With the assistance of the consulting actuary firm of Coates, Herfurth and England, we tested this assurance with a statistically valid number of procedures which in the aggregate accounted for from 90 per cent to 95 per cent of all payments to physicians. These procedures were run through the IBM machines again, first, on the basis of each individual county, and second, on the basis of a division of counties into ten geographical groups. A very high correlation developed from these tests when we compared the median fees charged in each county and each geographical group with the median fee charged statewide. We applied other more detailed tests, and because of the close correlation achieved, we felt that development of a relative value schedule for the state as a whole was statistically justified.

Most of the procedures listed in the study originated in the survey, which was prepared with a view to eliminating obsolete procedures and adding new and recent procedures. Your committee feels that the study now reflects with accuracy the actualities of the practice of medicine in California today. The additions were recommended to your committee by physicians representing each field of medical practice, together with the relative value they suggested should be assigned to each procedure added. When more than one specialty made differing recommendations as to the relative value of a procedure, the committee named a figure after consideration of all arguments.

We have been confronted with the proposition that we should make two relative value studies, one for general practitioners and the other for specialists. To forestall this proposition, may we say that this has been discussed by your committee, which considers such a proposal unworkable and not in keeping with the assignment of this committee. There are a number of reasons for this which became clear upon consideration.

To forestall any doubts we should say also that this study has nothing to do with recommending or setting anyone's fees. Nor are the results of this survey permanent. When it is necessary to make changes or to revise relative values, C.P.S. and insurance carriers may be informed of such necessity, and this committee is the logical study group which should evaluate and expedite such changes.

Our relative value study is divided into four separate sections: (1) Medicine, (2) Surgery, (3) Radiology and (4) Pathology. These sections should be considered and used separately. Relative values in one section should not be related to relative values in another.

We hope that this study will be used by insurance companies in setting their indemnities, that C.P.S. will use it in setting its payments, and that insured groups will use it to measure the sensibleness of the coverage for which they pay their premiums. We hope that it will make good, adequate medical coverage, which allows free choice of physicians, easier to produce, buy, sell and administer. We hope that it will be used to eliminate some of the obvious inequities in all fee lists, and that it will establish the exclusive right and the exclusive duty of medicine to set and interpret its fees and the methods by which physicians will be paid. We hope it will help adequately to protect the insured patient and fairly to compensate the physician.

Mechanics of the Study

The result of our statewide survey of physicians' fees was a list of median and modal fees for each procedure, expressed in dollars. But this was not our assignment. Our assignment was to discover and report the *relationship* or *relative value* that one procedure bears to another, not the dollars charged.

To illustrate, let us consider the fees for two surgical procedures—an appendectomy and an ocular muscle transplant. Looking at the median and modal dollar figures on our survey list, we found that the fee for an ocular muscle transplant was exactly twice that for an appendectomy. Then, on a relative value scale, if an appendectomy is one unit, an ocular muscle transplant is two units; if an appendectomy is 35 units, an ocular muscle transplant is 70 units.

We were not commissioned to report that the modal or median *fee* for an appendectomy in California is $125, $150 or $200, that the fee for an ocular muscle transplant is $250, $300 or $400. We *were* directed to determine the *relationship* of these and other procedures to each other.

Thus, if in a hypothetical community, $150 is the usual fee for an appendectomy, $300 should then be a fair fee for an ocular muscle transplant. In another area, where the usual fee for an appendectomy is $200, we could expect $400 to be the usual fee for an ocular muscle transplant. If an insurance company's schedule allows $125 for an appendectomy, it should reasonably allow $250 toward an ocular muscle transplant *if* the proper relative values, as determined by our study, are applied and *if* the indemnity for an ocular muscle transplant is to bear the same relation as the indemnity for an appendectomy to usual fees in California.

Not wanting to express these relationships in dollars but in unit values, we multiplied all of the dollar figures resulting from our survey by an arbitrarily chosen "conversion factor."

Multiplying all dollar figures by the same "conversion factor" conserved the *relationship,* but elim-

inated the dollar figures from our *relative value* study. The result was a *unit value* rather than a dollar value for each procedure.

To illustrate, suppose our arbitrarily chosen conversion factor were .25 (which it was not). And suppose the median and modal fee for a hospital visit in California were $4.00 (which it is not). We multiply $4.00 by .25 which equals 1.0, the relative unit value of a hospital visit. Multiplying each dollar figure on the schedule by .25, we come up with a relative value list (as shown in Table 1).

What good is such a list of relative values? How do you use it? How can you convert these relative values back to dollars?

Suppose you want to adjust your individual fees in order to correlate them to the relative fees charged by a majority of California physicians. If, for example, you normally charge $200 for an appendectomy (3261), which has a relative value of 35.0, how much should your fee be for a Cesarean section (4801) which has a relative value of 50.0? Use this formula: $200 is to 35 as "$x$" is to 50. Express it like this: $200/35=$x/50$. Multiply $200 × 50, which is $10,000. Divide by 35 and your answer is $285.71—or the dollar value of a Cesarean section.

Or you can establish your own conversion factor. Using our example, $200 for an appendectomy is approximately 571 per cent of 35, its relative value. Take 571 per cent of the relative value of each procedure and you will have a fee schedule with correct relative values based upon $200 for an appendectomy. You will arrive at a schedule (see Table 2).

Relating medical fees one to another: If your fee for a follow-up office visit is $4.00, your conversion factor would be 400 per cent ($4.00 divided by 1 equals 4.0 or 400 per cent). Then your own medical relative value schedule, based upon a $4.00 office call, would be (see example, Table 3).

If you do laboratory work, and want to test the relationship of your fees one to another against the relative value scale, select a common procedure, such as a complete blood count (8628). If, for example, you charge $5.00 for this procedure, which has a relative value of 1.0 on the pathology relative value scale, your factor is 500 per cent. (For hypothetical examples, see Table 4.)

Other purposes of the relative value study are to assist insurance companies in setting their indemnity schedules and to assist the purchaser of insurance in testing the benefits he is buying.

Here is how one may use the relative value study to test an insurance company indemnity schedule:

A typical schedule starts with $150 for an appendectomy. The relative value for an appendectomy is 35; $150 divided by 35 gives a conversion factor of 428 per cent. Now let's test some of the other items on the schedule, using $150 for an appendectomy as the base (see Table 5).

We must reiterate that the relative value study is actually four separate studies within the fields of Medicine, Surgery, Radiology and Pathology.

If the surgical values were to be established with a medical fee for a base, small adjustment in the medical fee would produce enormous change in the surgical fee (for example, see Table 6).

TABLE 1

Procedure No.	Procedure	Relative Value in Units
001	Office visit (first call—routine history and necessary examination)	2.0
002	Hospital visit	1.0
003	First home visit	2.0
025	Home visit (11 p.m. to 8 a.m.)	2.5
004	Home visit—each additional member, same household	.8
006	Follow-up office visit	1.0
021	Follow-up home visit	1.5
005	Mileage—per mile, one way, beyond radius of 10 miles, office or home	.2

TABLE 2

Procedure No.	Procedure	Relative Value		Your Conversion Factor	Fee (Nearest Even $)
3261	Appendectomy	35	×	571%	$200.00
4801	Classic Cesarean section	50	×	571%	285.00
4318	Prostatectomy retropubic	70	×	571%	400.00
4613	Hysterectomy	50	×	571%	285.00
2992	Tonsillectomy	15	×	571%	86.00

TABLE 3

Procedure No.	Procedure	Relative Value		Your Conversion Factor	Fee
001	Office visit (first call—routine history and necessary examination)	2.0	×	400%	$8.00
002	Hospital visit	1.0	×	400%	4.00
003	Home visit	2.0	×	400%	8.00
025	Home visit (11 p.m. to 8 a.m.)	2.5	×	400%	10.00
004	Home visit — each additional member, same household	.8	×	400%	3.20
006	Follow-up office visit	1.0	×	400%	4.00
027	Consultation requiring complete examination, office, hospital or home	7.0	×	400%	28.00
	(etcetera)				

TABLE 4

Procedure No.	Procedure	Relative Value		Your Factor	Fee
8628	Complete blood count	1.0	×	500%	$5.00
8636	Bone marrow, examination of material	3.0	×	500%	15.00
8658	Coagulation time (Lea & White)	.6	×	500%	3.00
8710	Prothrombin utilization	1.5	×	500%	7.50
8930	Urine — routine chemical qualitative	.2	×	500%	1.00
	(etcetera)				

TABLE 5

Procedure	Insurance Company Indemnity	Relative Value		Factor	On Basis of Relative Values if Appendectomy Is $150, Indemnity Should Be
Appendectomy	$150.00	35	×	428%	$150.00
Amputation of finger	37.50	12.5	×	428%	53.50
Simple mastectomy	150.00	30	×	428%	128.40
Laryngectomy	300.00	80	×	428%	342.40
Total gastrectomy	300.00	100	×	428%	428.00
Hemorrhoidectomy:					
External	37.50	5	×	428%	21.40
Internal	75.00	25	×	428%	107.00
Total hysterectomy	225.00	60	×	428%	256.80
Tonsillectomy	45.00	15	×	428%	64.20

TABLE 6

Procedure No.	Procedure	Relative Value	Fee	Fee	Fee	Fee
006	Follow-up office visit	1.0	$ 3.00	$ 4.00	$ 5.00	$ 6.00
2114	Total gastrectomy	100.0	300.00	400.00	500.00	600.00

TABLE 7.—*Illustrating the injustice of across-the-board changes in fee schedules*

	Fee Schedule	Required Overhead	Net to Physician	Decrease Fee 20 Per Cent	Net to Physician	Decrease in Net to Physician
Procedure X	$25.00	50%	$12.50	$20.00	$7.50	40%
Procedure Y	25.00	25%	18.75	20.00	13.75	26%

Each change of $1.00 in the follow-up office visit produces a $100.00 change in the surgical fee—if the medical procedure is used as the base to determine the surgical fee.

There are many other reasons for not relating fees in one section to those in another. One of them is the problem of varying overhead, of expense for equipment, materials, personnel and the like. If, for example, the C.P.S. $4,200 income ceiling schedule were exactly 20 per cent lower than the $6,000 schedule, across-the-board, great injustice would be done to those physicians who do procedures which result in a larger overhead (for example, see Table 7).

Each dollar taken off a gross fee comes out of the physician's net. In those procedures where the cost of providing the service is high, smaller reductions can be tolerated. A uniform fee reduction that might leave some profit for the surgeon may make it impossible for the medical man, radiologist or pathologist to exist.

For these and other good reasons, we recommend that the values established in each section of this study be related only within each of its four sections, and never between sections.

Recommendations of the Committee on Fees

Commission on Medical Services

The Committee on Fees recommends that the four schedules of relative values, relating medical services, surgical services, pathology and radiology be accepted at this time and that this study of relative values be furnished to the county medical societies, C.P.S. and other interested groups or persons so that they may utilize this study to evaluate the various existing fee schedules in use in their respective areas of interest.

The committee further recommends that any new schedules of fees or any changes in existing schedules be so arranged as to conform exactly to the format presented in this study.

The committee also strongly urges that the same coding system be utilized so that a uniform coding system and a uniform terminology can be developed for all existing schedules in California.

The committee further recommends that this be a continuing study and that at periodic intervals it be critically analyzed and necessary adjustments made.

FRANCIS J. COX, M. D.
Chairman, Committee on Fees

February 11, 1956.

Report on Use of Salk Vaccine

Prepared by a special committee appointed by the Council to consider the present status of Salk vaccine

On May 4, 1955, the Council of the California Medical Association issued a note expressing anxiety over the Salk vaccine and disapproval of the manner in which it had been introduced. The committee report herein presented was requested by the Council to formulate a statement of policy for the current use of poliomyelitis vaccine. Your committee unanimously subscribed to the following:

1. The vaccine employed in the spring of 1955 proved to have dangers which made it unsatisfactory for further use. These dangers were later shown to be implicit in the methods of manufacture and testing then recommended.

2. Methods of production and of safety testing have been repeatedly revised and refined to a point where safety is as nearly assured as it is likely to be in any similar virus vaccine—absolute safety being almost unattainable.

3. Experience with vaccine used in the spring and summer of 1955, whatever its relative safety, provides evidence of immunity response as determined by serologic studies and by decrease of paralytic disease in epidemic situations. This encourages the belief that a vaccine of this nature may prove to be effective.

4. Final evaluation of the protective effect of the vaccine now available must await the accumulation of sufficient evidence to indicate if increased safety has been accompanied by unimpaired antigenicity.

5. It is hoped that additional experience and surveillance will define the limitations of protection induced. Only thus may be determined the virtue of vaccines of this nature, the duration of immunity, the necessity of recall injections and finally to point the way toward better vaccines with improved antigenicity and unequivocal safety.

6. The committee recommends approval of the further use by physicians and health agencies of the present vaccine licensed and released under current standards.

Sidney J. Adler, M.D.
Albert G. Bower, M.D.
Harold K. Faber, M.D.
Malcolm H. Merrill, M.D.
Edward B. Shaw, M.D., *Chairman*

Executive Committee Minutes

Tentative Draft: Minutes of the 255th Meeting of the Executive Committee of the California Medical Association, Bohemian Club, San Francisco, January 24, 1956.

The meeting was called to order by Chairman Heron at 7:00 p.m., Tuesday, January 24, 1956, in the Directors' Room, Bohemian Club, San Francisco.

Roll Call:

Present were President Shipman, Council Chairman Lum, Executive Committee Chairman Heron, Secretary Daniels and Editor Wilbur.

A quorum present and acting.

Present by invitation were Doctors John R. Upton and DeWitt K. Burnham and Messrs. John Hunton and Howard Hassard.

1. *Fresno Blood Banking Situation:*

Discussion was held on the present blood banking situation in Fresno, where the nonprofit blood bank sponsored by the Fresno County Medical Society and financed by the California Medical Association is operating at a loss and a competing proprietary bank is continuing to serve about two-thirds of the blood needs of the area.

On motion duly made and seconded, it was voted to ask the members of the Executive Committee, together with the District Councilor of the area, to meet with officials of the Fresno County Medical Society, to determine whether or not the members in the area wish to support the society-sponsored blood bank.

2. *Polio Vaccine:*

Doctor Wilbur reported that the start of a new poliomyelitis season would bring a renewed demand for factual information on the vaccine available for inoculations. He suggested that a committee of five experts in this field be appointed, to produce a statement which could be published in the journal for the information of all members. On motion duly made and seconded, this suggestion was approved.

3. *Committee on Rural and Community Health:*

On motion duly made and seconded, it was voted to approve the attendance of Doctor Robb Smith, chairman of the Committee on Rural and Community Health, at the Rural Health Conference planned by the Council on Rural Health of the American Medical Association to be held in Portland, Oregon, March 8 to 10.

4. *European Tour:*

Mr. Hunton reported that two airlines were preparing conducted tours of European countries, including Russia, which they wished to offer to members of the Association. He asked if the complimentary tours, available at the rate of one tour for each twenty sold, might be used by science writers who might write stories on European medical care, or by others. It was agreed to secure details on the proposed tours and discuss the subject further at the next Council meeting.

5. *Central Office Arrangements:*

Mr. Hunton reported that for several years the office routine had called for only a skeleton staff on Saturdays, principally for the purpose of taking incoming telephone calls, and that there was practically no telephone business on these days. It was agreed that regular Saturday assignments might be dispensed with, provided a standby telephone service were provided to assist any members who might be calling.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 10:00 p.m.

IVAN C. HERON, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

Proposed Constitutional Amendment

(Second Publication)

The following proposal was introduced at the 1955 Annual Session of the California Medical Association. It is to be acted upon at the 1956 session:

WHEREAS, a new corporation has been established called PHYSICIANS' BENEVOLENCE FUND, INC., to administer the duties under Section 6 of Article IV of the Constitution of the California Medical Association; now, therefore, be it

***Resolved:* That Section 6 of Article IV of the Constitution which now reads:**

> **"At least $1.00 out of the annual dues paid by each active member of the Association shall be allocated to the Physicians' Benevolence Fund and shall only be used for the purposes as set forth in the By-Laws."**

is hereby amended to read as follows:

> **"At least $1.00 out of the annual dues paid by each active member of the Association shall be allocated to the Physicians' Benevolence Fund, Inc., a corporation, and shall be used for the purposes as set forth in that corporation's Articles and By-Laws."**